BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **GEORGE SEIN, M.D.** Holder of License No. **13863** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0129A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on April 12, 2007. George Sein, M.D., ("Respondent") appeared before the Board with legal counsel Tom Slutes for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 13863 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0129A after receiving a complaint regarding Respondent's care and treatment of a fifty-two year-old male patient ("LS"). LS first presented to Respondent on August 3, 2000 complaining of allergic rhinitis. Respondent ordered laboratory studies and requested LS return for a follow-up examination in September. LS did not return for the studies or the follow-up examination. LS next presented to Respondent on February 27, 2001 for hand pain and requesting diuretics. Respondent scheduled LS for a more comprehensive examination on May 3, 2001.

4. LS presented for the May 3, 2001 examination. During the examination Respondent noted LS's brother had prostate cancer. Respondent found no genitourinary

symptoms on review of symptoms and noted a negative rectal examination. At this visit Respondent noted laboratory results dated April 25, 2001 were positive for an elevated cholesterol level. Respondent prescribed Lipitor and ordered an additional laboratory study and follow-up office visit. LS did not schedule the follow-up visit when he checked out, but was instructed to call and set up the appointment.

5. Although ordered by Respondent on May 3, LS did not undergo laboratory testing until June 7, 2001. The laboratory results revealed a lowered cholesterol (indicating compliance with the Lipitor therapy). The results also showed a new finding of a significantly elevated PSA level. Respondent's notes indicate he reviewed the laboratory results the same day they were received. LS and his wife reported to the Board that they attempted to contact Respondent's office for a follow-up appointment six times, beginning on May 10, 2001. LS reported he went to Respondent's office in June and was told that since Respondent's office had not contacted him, it meant the results were normal. Respondent's phone log does not list any calls from LS and there is no documentation of LS's June visit to the office inquiring about his lab results. LS opted to change health care providers and underwent further testing. LS was then diagnosed with prostatic carcinoma with PSA of 227.

6. Respondent's office policy is that all test results are brought to his personal attention and he looks at them in conjunction with the patient's chart. If the patient has a return appointment scheduled he files the chart with the lab results and awaits the patient's next visit. Respondent rarely gives results to patients over the phone because he prefers to have a face-to-face discussion and, in the case of a patient with multiple medical conditions, he will never entertain a phone discussion. Respondent acknowledged it was his responsibility to communicate test results. Respondent maintained that waiting for the patient to call back for results has worked well in his practice, particularly when the patient has indicated a willingness to come

back. Respondent agreed it was equally important to notify patients who choose not to return to his care.

7. Although Respondent was aware of the PSA results from the June 7 test he did not communicate the results to LS because the chart indicated LS was going to call back for an appointment and Respondent felt he had not proven prostate cancer at that time. Respondent does not have a mechanism for informing patients of test results if the patient does not make the follow-up appointment. Respondent expected LS to come in and allow him to discuss the case, but LS had demonstrated he was relatively unreliable with appointments and coming back to Respondent. Respondent agreed that although the initial PSA did not prove cancer, in a patient with a sibling who had prostate cancer at least a follow-up visit is required.

8. The standard of care required Respondent to communicate any significant abnormal laboratory results directly to LS.

9. Respondent deviated from the standard of care when he did not communicate the abnormal PSA levels directly to LS.

10. LS's diagnosis of prostate cancer was delayed.

11. It is aggravating that Respondent received an advisory letter 1997 for failing to follow-up on abnormal laboratory results.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(ll) ("[c]onduct the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failure to communicate to the patient the results of an abnormal laboratory test delaying the diagnosis of prostate cancer.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 5th day of June 2007.

ARIZONA MEDICAL BOARD
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STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 7th day of June, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 7th day of June, 2007, to:

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George Sein, M.D.
Address of Record